STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

Home Instead Senior Care
Petitioner **File No. 21-1612**

v

MemberSelect Insurance Company
Respondent

Issued and entered
this 14th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On October 13, 2021, Home Instead Senior Care (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of MemberSelect Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on September 6 and 16, 2021 and October 1, 2021. The Petitioner now seeks reimbursement in the total amount it billed for the dates of service at issue. The Department accepted the request for an appeal on October 27, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on October 27, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on November 3, 2021. The Department issued a notice of extension to both parties on December 1, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health aide services rendered from July 2, 2021 through September 14, 2021 under Healthcare Common Procedural Coding

System (HCPCS) Level II code S9122, which is described as a home health aide or certified nurse assistant providing care in the home, per hour.

With its appeal request, the Petitioner submitted documentation that included five Explanation of Benefits (EOB) letters, a narrative outlining the reasons for the appeal request, a copy of a physician's prescription order for attendant care services, and invoices for the dates of service at issue. In its narrative, the Petitioner explained that attendant care services have been rendered to the injured person "24 hours a day, 7 days a week, since May 2019." The Petitioner further noted:

> We have prescriptions from [the injured person's physician] ordering this care. Our hourly rate started at $[redacted] and has gone up to $[redacted]. The payments received from [the Respondent] from 2019 through July 1, 2021 were paid at almost 100 percent regularly. However, effective July 2, 2021, [the Respondent's] payments were significantly less. The payments received for dates of service [at issue] have been at $[redacted] per hour. That is approximately 50-55% of our charges.

In its denials, the Respondent based its reimbursement amount on the "recommended allowance" from the "applicable percentage of the Provider Charge Description Master [CDM]" and "further adjusted by the annual adjusted [Consumer Price Index (CPI)]." With its reply, the Respondent included a response letter and a copy of a CDM provided by the Petitioner. The Respondent further stated:

> [The Respondent has] reviewed the appeal and is unable to provide a response on this case because the denial does not involve a Utilization Review or Fee Schedule denial. The [Petitioner] is disputing their own CDM, and all bills in question have been priced according to the CDM [the Petitioner] submitted to [the Respondent.]

On October 27, 2021, the Department requested the Petitioner's 2019 CDM. See MCL 500.3157(7). The Petitioner submitted its CDM to the Department on October 27, 2021.[1]

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

[1] The Department also requested that the Petitioner submit documentation in the form of bills and reimbursements from insurers to substantiate the rate charged on January 1, 2019. The supporting documentation confirmed an average charge of $[redacted] per hour for HCPCS Level II code S9122.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

The Department determined that HCPCS code Level II S9122 is not payable under Medicare. Accordingly, to calculate the appropriate reimbursement amount for S9122, the Department relied on information regarding the Petitioner's average charge amount for procedure code S9122 in 2019. Pursuant to MCL 500.3157(7), the amount payable for the HCPCS Level II code and dates of service at issue is as follows:

HCPCS code	January 1, 2019 average amount charged	55% of January 1, 2019 average amount charged	4.11% CPI adjustment	Amount payable for the dates of service at issue
S9122	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is not entitled to additional reimbursement for HCPCS Level II code S9122 for the dates of service at issue.

IV. ORDER

The Director upholds the Respondent's determinations dated September 6 and 16, 2021, and October 1, 2021.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review

should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford